

FAMILY PRACTICE RURAL ROTATION PROGRAM

Resident's Letter of Agreement

Name of Resident _____

Residency Program _____

Date of Planned Rotation _____

Directions: Program Director: Please sign where indicated, retain a copy for your records, then forward the original to the Rural Rotation Supervisor.

Rural Rotation Supervisor: Please sign where indicated, retain a copy, then forward a copy to:

Stacey Silverman, Program Director
The Texas Higher Education Coordinating Board
Universities and Health-Related Institutions Division
P. O. Box 12788
Austin, Texas 78711
Phone: (512) 427-6540

I, the undersigned, hereby certify that the resident going on this rotation is in good standing at my program and meets all requirements set out in the attached guidelines. I also certify that the resident has appropriate liability insurance coverage for training activities that will occur during this rotation, as attested by the copy of the facesheet for the resident's insurance policy here attached.

I also agree to abide by the attached Program Guidelines for the Family Practice Rural Rotation, which I have read and understand.

Signature of Program Director

Date

I, the undersigned, hereby certify that I meet all requirements for Rural Rotations Supervisors set out in the attached guidelines. I also certify that I will submit all required evaluations and that I will not encourage or knowingly permit any activities that could endanger the resident's board eligibility, including permitting unsupervised patient care.

I also agree to abide by the attached Program Guidelines for the Family Practice Rural Rotation, which I have read and understand.

Signature Supervisor

Date